

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10672

CERTIFICATE OF DEATH

10672

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 OAKLAND MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELLEN JANE ASH.				4. DATE OF DEATH Month Day Year OCT. 23 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL-3-1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SPRINGS PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JOHN BENDER				14. MOTHER'S MAIDEN NAME HOLDA GLASS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ROBERT ASH Address OAKLAND MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke 3 mos ago							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-23-57 , to 10-20-57 , that I last saw the deceased alive on 10-20-57 , and that death occurred at 11 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D. 58 2nd ST OAKLAND MD 10-25-57				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		OCT-27-1957		GLADES CEMETERY		NEAR BITTINGER MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24b. REGISTRAR'S SIGNATURE [Signature]	
24a. RECD. BY REGISTRAR 10/27/57				DATE			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

OCT 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10673

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON	
3. NAME OF DECEASED (Type or print) First LEVI Middle MARTIN Last BITTINGER		4. DATE OF DEATH Month OCT Day 27 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODS		10b. KIND OF BUSINESS OR INDUSTRY CUTTING POSTS	
11. BIRTHPLACE (State or foreign country) GARRETT CO, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVI BITTINGER		14. MOTHER'S MAIDEN NAME REBECCA BITTINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-18-4813	
17. INFORMANT Robert Bittinger, Swanton RD #2 MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 440.0 Conditions, if any, which gave rise to immediate cause (b) Scientific Heart Disease DUE TO 440.0 cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Immed. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481 And "21" for past week		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Feaster Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 4 etidg	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-30-57	
22c. NAME OF CEMETERY OR CREMATORY LAUREL HILLS		22d. LOCATION City, town, or county MASCON, ALLEGANY (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman - Grantsville MD		24a. REC'D BY REGISTRAR NOV 1 1957	
ADDRESS Grantsville MD		24b. REGISTRAR'S SIGNATURE Julia Rowan	

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STATEMENT OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10674

10674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>			
c. LENGTH OF STAY IN TB <u>LIFE</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARVIN</u> Middle <u>GLEN</u> Last <u>CALLIS</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 11, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NORTHERN HIGH</u>			
11. BIRTHPLACE (State or foreign country) <u>ACCIDENT MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FRANK CALLIS</u>				14. MOTHER'S MAIDEN NAME <u>JANE BOWMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>912-38-5979</u>			
17. INFORMANT Address <u>Mrs. Lena Callis, Accident, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/17/55</u> , 19 <u>55</u> , to <u>10/17/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/24/57</u> , 19 <u>57</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>25 ANDER ST</u> DATE SIGNED <u>10/17/57</u>							
ACTUAL SIGNATURE <u>E. J. Baumgartner</u> M.D. <u>25 ANDER ST</u>				DATE SIGNED <u>10/17/57</u>			
PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER</u>				<u>OAKLAND MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 20, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAR CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>ACCIDENT GARRETT CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u> ADDRESS <u>Frederick Md</u>				24a. RECEIVED BY REGISTRAR <u>Julius K. Rowan R. 9</u> DATE <u>20/57</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. 12

BUREAU V. 3.

OCT 29 1957

RECEIVED

10675

CERTIFICATE OF DEATH

106776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT XI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARRETT NURSING HOME</u>				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>DEWITT</u> Last <u>DEWITT</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 15, 1861</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ACCIDENT MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>SOLOMAN BOYER</u>			
14. MOTHER'S MAIDEN NAME <u>SALLY MEESE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Whitfield Dewitt, McHenry, Md</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOCLEROTIC CAV DISEASE</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>NOV 1</u> , 19 <u>56</u> , to <u>OCT. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT. 15</u> , 19 <u>57</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. I. Baumgartner</u> M.D. <u>25 ALDER ST</u>				DATE SIGNED <u>10/28/57</u>			
PHYSICIAN'S NAME (Type) <u>E. I. BAUMGARTNER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOYES METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>HOYES GARRETT CO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman, Huntville, Md</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>10/27/57</u>		24b. REGISTRAR'S SIGNATURE <u>John G. Rowen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

116

BUREAU V. 3

NOV 12 1957

RECEIVED

116

10676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park				c. LENGTH OF STAY IN 1b 43 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 1/2 Mi. So. Deer Park, Md.				e. STREET ADDRESS R. D. Deer Park, Md.			
3. NAME OF DECEASED (Type or print) First Coy Middle Webster Last Ervin				4. DATE OF DEATH Month October Day 25 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1894	9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 25	Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & Farmer, cutting timber in woods				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Isaac Ervin				14. MOTHER'S MAIDEN NAME Sarah Jane Kitzmiller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2994		17. INFORMANT Victor Ervin		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial heart disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 years 6 yrs 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland, Md.	
20f. (City or town) Oakland, Md.				20g. (County) Oakland, Md.		20h. (State) Oakland, Md.	
21. I certify that I attended the deceased from Jan 3 , 19 55 , to Oct 24 , 19 57 , that I last saw the deceased alive on Oct 31 , 19 57 , and that death occurred at 1:30 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. Mance M.D.				DATE SIGNED 26 Oct 57			
PHYSICIAN'S NAME (Type) A. E. Mance M.D.				ADDRESS Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1957		22c. NAME OF CEMETERY OR CREMATORY Paugh Cemetery		22d. LOCATION (City, town, or county) (State) 2 1/2 Mi. S. Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				24a. REC'D BY REGISTRAR DATE 10/27/57		24b. REGISTRAR'S SIGNATURE J. H. Howard	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9-712, 10-23-57 at

10677

CERTIFICATE OF DEATH

Reg. Dist. No.

10677/66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AURORA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First FRONIE Middle AMELIS Last FINT				4. DATE OF DEATH Month OCTOBER Day 13 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 18, 81	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RED OAK, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN THOMAS CROWE				14. MOTHER'S MAIDEN NAME MARTHA ARONHALT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address "HUSBAND" DANIEL LUTHER FINT, AURORA, W.VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cerebro-vascular Disease DUE TO (c) Arterio-sclerosis						INTERVAL BETWEEN ONSET AND DEATH 30 hours 6 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 1957 to 13 Oct 1957 that I last saw the deceased alive on 12 Oct 1957 and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 13 Oct 57			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.		OAKLAND,		MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 15, 1957	22c. NAME OF CEMETERY OR CREMATORY Aurora		22d. LOCATION (City, town, or county) (State) Aurora W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		ADDRESS Davis, W.V.		24a. REC'D BY REGISTRAR DATE 10/15/57			
				24b. REGISTRAR'S SIGNATURE John A. Rowan			

24b. REGISTRAR'S SIGNATURE
John A. Rowan

BUREAU V. S.

OCT 10 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678

CERTIFICATE OF DEATH

10678/66

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE MARYLAND b COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 1, OAKLAND	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS BOX 163	
3. NAME OF DECEASED (Type or print) First ETHEL Middle MARIE Last GILSON		4. DATE OF DEATH Month OCTOBER Day 17 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY W. GILSON		14. MOTHER'S MAIDEN NAME BROOKS, CINDRELLA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO	
17. INFORMANT "SELF"		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia & Hydronephrosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix uteri DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 to OCT. 17, 1957 , that I last saw the deceased alive on OCT. 17, 1957 , and that death occurred at 12:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 17 Oct 57			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D. OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 20-57	22c. NAME OF CEMETERY OR CREMATORY Deer Park	22d. LOCATION (City, town, or county) (State) Deer Park Md
23 FUNERAL DIRECTOR'S SIGNATURE Emory Golden ADDRESS OAKLAND MD.		24a. REG'D. BY REGISTRAR DATE 10/20/57	24b. REGISTRAR'S SIGNATURE John C. Hagan JR

BUREAU V. S.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10679

CERTIFICATE OF DEATH

10679 66

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				e. STREET ADDRESS STAR ROUTE - PEERLESS			
3 NAME OF DECEASED (Type or print) First BIRDIE Middle BLANCHE Last HARVEY				4. DATE OF DEATH Month OCTOBER Day 23 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2, 1875		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES WILSON			
14. MOTHER'S MAIDEN NAME MELISSA ELIZABETH WEBB				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO NONE				17. INFORMANT MARTHA E. WEYANT Address AKRON, OHIO			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO RT Lobar (basal) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last arterio sclerosis (b) arterio sclerosis (c) arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 470X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. [City or town] (County) (State)				20g. [City or town] (County) (State)			
21. I certify that I attended the deceased from 10/21/1957 to 23 Oct 1957 , that I last saw the deceased alive on 23 Oct 1957 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 24 Oct 1957			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.				O A KLAND, MD.			
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		10/26/57		I.O.O.F. Cemetery		Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE O A Sharkless ADDRESS Blaine, W. Va.				24a. RECEIVED BY REGISTRAR DATE 10/26/57		24b. REGISTRAR'S SIGNATURE Julius A. Roman	

BUREAU V. S.

RECEIVED

10680

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS Nikep			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle C. Last Kiddy				4. DATE OF DEATH Month October Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1884	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Kiddy				14. MOTHER'S MAIDEN NAME Jane Clayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lottie Kiddy		Address Nikep, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mo							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 30 , 19 57 , to October 4 , 19 57 that I last saw the deceased alive on Sept 1 , 19 57 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 10/6/57							
ACTUAL SIGNATURE E. L. Baumgartner M.D.				DATE SIGNED 10/6/57			
PHYSICIAN'S NAME (Type) E. L. BAUMGARTNER				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/57		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 10/7/57	
				24b. REGISTRAR'S SIGNATURE John H. Brown		RR	

BUREAU V. S.

OCT 9 1907

RECEIVED

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10681 10681 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4th St.		e. STREET ADDRESS 4th St.	
3. NAME OF DECEASED (Type or print) Donna Hanna Littman		4. DATE OF DEATH Month October Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1899
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife & retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Hanna		14. MOTHER'S MAIDEN NAME Ella Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Julius B. Littman		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis & Diphtheria DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic muscular atrophy DUE TO (c) 4 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1954 to Oct 28, 1957 , that I last saw the deceased alive on Oct 28, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 10/30/57 SIGNATURE E. I. Baumgartner M.D. Del. Cloud PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D. Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/1957	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		24a. REC'D BY REGISTRAR DATE 10/31/57	
24b. REGISTRAR'S SIGNATURE Julius B. Littman			

RECEIVED

NOV 12 1907

BUREAU V. S.

10682

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF LAWRENCE First RAY Middle MC COMBIE Last				4. DATE OF DEATH OCTOBER 10 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-58		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shreveport, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT LAWRENCE MC COMBIE				14. MOTHER'S MAIDEN NAME GLADYS MAE SHIPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT " GLADYS M MC COMBIE (MOTHER) FRIENDSVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 40X IMMEDIATE CAUSE (a) Typhoid Fever DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. L. Baumgartner M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) E. L. BAUMGARTNER, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Steel Cemetery		22d. LOCATION (City, town, or county) (State) near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory B. Holden				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 10/12/57 DATE	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 12 1957

RECEIVED

10/15

10683

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First THOMAS Middle MC Last ROBIE				4. DATE OF DEATH Month OCTOBER Day 1 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/72		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS MC ROBIE				14. MOTHER'S MAIDEN NAME LUCY MC ROBIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS JAMES SHAFER SWANTON MD			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic renal vascular disease 44dX DUE TO Arterio-sclerotic renal vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal arterio-sclerotic (c) Renal arterio-sclerotic							INTERVAL BETWEEN ONSET AND DEATH 8 years 8 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9/24/1957 to 10/1/1957 , that I last saw the deceased alive on 10/1/1957 , and that death occurred at 12:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 10/5/57			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-3-1957		22c. NAME OF CEMETERY OR CREMATORY MC ROBIE CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR SWANTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR DATE 10/5/57	
				24b. REGISTRAR'S SIGNATURE William H. Power			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUMMAU V. S.

OCT

RECEIVED

10684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10684/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD. b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEKS NURSING HOME		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) JOHN First NELSON Middle MICHAEL Last		4. DATE OF DEATH OCT. Month 1 Day 1957 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB-9, 1879 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CONRAD MICHAEL		14. MOTHER'S MAIDEN NAME AMANDA SAUAGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 26-07-6061	
17. INFORMANT ARTHUR MICHAEL Address 1850 LANCASHIRE DETROIT MICH.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 934 (b) ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture RT. femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT , 19 57 to OCT , 19 57 , that I last saw the deceased alive on SEPT 30 , 19 57 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ALDER ST OAKLAND MD DATE SIGNED 10/1/57			
ACTUAL SIGNATURE E. J. Baumgartner		PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-3-1957	
22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR 10/3/57 DATE 10/3/57 REGISTRAR'S SIGNATURE John G. Bowen	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

RECEIVED

1 10685 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10685/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. No. Swanton		e. STREET ADDRESS 4 Mi. No. Swanton	
3. NAME OF DECEASED (Type or print) First Stella Middle Florence Last Paugh		4. DATE OF DEATH Month October Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1875
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Howell		14. MOTHER'S MAIDEN NAME Delilah Wilt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Stewart Paugh		Address Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio. Renal Disease 442X DUE TO Arteriosclerotic Cardio. Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO Obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mos 7 years 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-23-57 to 9-30-57 , that I last saw the deceased alive on 9-30-57 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James H. Feaster Jr. M.D. 582nd St. Oakland - Md. 10-4-57			
ACTUAL SIGNATURE James H. Feaster Jr.		PHYSICIAN'S NAME (Type) James H. Feaster Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY North Glade Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		24a. RECEIVED BY REGISTRAR DATE 10/5/57	
ADDRESS Oakland, Md.		24. REGISTRAR'S SIGNATURE Julius C. Rowan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10686

CERTIFICATE OF DEATH

1068666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle WALTER Last PHILLIPS				4. DATE OF DEATH Month OCTOBER Day 12 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/81	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROADER				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JACOB PHILLIPS				14. MOTHER'S MAIDEN NAME UNKNOWN Ella Poling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO				16. SOCIAL SECURITY NO 234-12-0565		17. INFORMANT Address DAUGHTER (MRS. PEARL FREELAND)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Ate betanin, Pneumonitis, right lung DUE TO 6 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Cerebral Vascular Accident DUE TO 2 mos. (c) Arteriosclerotic Cardio Vascular Disease 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/8 , 19 57 , to 10/12/ , 19 57 , that I last saw the deceased alive on 10/12/ , 19 57 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 OAK STREET DATE SIGNED OCTOBER 12, 1957							
ACTUAL SIGNATURE Herbert H. Leighton M.D.							
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		12/14/57		Knight of Pythias Cemetery Newburg, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton				ADDRESS Terra Alta		24a. REC'D BY REGISTRAR DATE 12/14/57	
				24b. REGISTRAR'S SIGNATURE Judith Rowan			

RECEIVED

OCT 17 1967

BUREAU A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10687 66

10687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAURICE Middle L. Last SISK				4. DATE OF DEATH Month OCTOBER Day 11 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/22/75	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engin Tender for Balto. & Ohio R R Co				10b. KIND OF BUSINESS OR INDUSTRY DEER PARK, MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME HENRY, SISK				14. MOTHER'S MAIDEN NAME DELLA SPENCER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 705-12-3280		17. INFORMANT Mrs. D. E. Callis Address Mt. Lake Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia							3 days
DUE TO (b) Cerebral Vascular Accident							5 days
DUE TO (c) Atherosclerotic Cardiovascular Disease							15-20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10/9/1957 to 10/11/1957 that I last saw the deceased alive on 10/11/1957 and that death occurred at 10:05 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md.			
DATE SIGNED Oct 11, 1957							
PHYSICIAN'S NAME (Type) HERBERT LEIGHTON M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/1957		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 10/14/57	
				24b. REGISTRAR'S SIGNATURE Julius A. Rowan			

RECEIVED

OCT 17 1957

BUREAU V. S.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10688
CERTIFICATE OF DEATH

10688/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS ROUTE #1	
3. NAME OF DECEASED (Type or print) Brenda Kay BABY GIRL		4. DATE OF DEATH Month OCTOBER Day 1 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1957
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME TICHINEL, JAMES		14. MOTHER'S MAIDEN NAME BOYCE, JUANITA VIRGINIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT James Tichinel, R#1, Swanton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE CONGENITAL ANOMALIES DUE TO Bilateral Harelip, cleft palate, Imperforate anus and Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO Polydactylism (b) 3 days (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/29 , 19 57 , to 10/1 , 19 57 , that I last saw the deceased alive on 10/1 , 19 57 , and that death occurred at 12:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) R#1, Swanton, Md. DATE SIGNED 10-2-57		22. NAME OF CEMETERY OR CREMATORY Turner Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Frazier, Jr. ADDRESS Blaine, W. Va.		24. REC'D BY REGISTRAR 10/2/57	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial		26. DATE THEREOF Oct. 2/57	
27. LOCATION (City, town, or county) (State) R#1, Swanton, Md.		28. REGISTRAR'S SIGNATURE John A. Brown	

RECEIVED
OCT 10 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

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10689

10689

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. STREET ADDRESS ROUTE # 1			
3. NAME OF DECEASED (Type or print) First MIDDLE Last KATHLEEN LENORE TICHNELL				4. DATE OF DEATH Month Day Year OCTOBER 28 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1905		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK JUNKINS				14. MOTHER'S MAIDEN NAME MAUDE GRIFFITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Address ARTHUR TICHNELL - ROUTE # 1 - SWANTON, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> 126.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957, to OCTOBER 27, 1957, that I last saw the deceased alive on October 27, 1957, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Andrew E. Mance M.D. Oakland Md 29 Oct 57 PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D. OAKLAND, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Tichnell Cem.		22d. LOCATION (City, town, or county) (State) GARRETT Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.S. ROOD Westernport, Md				24a. REG'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE John P. Pownall	

162

BUREAU V. S.

NOV 12 1957

RECEIVED
10/31/27

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

5N01167N15711

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10690

CERTIFICATE OF DEATH

10690

Reg. Dist. No

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY GARRETT	MARYLAND	STATE MARYLAND	COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER	LENGTH OF STAY (in this place) 56 YRS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER	
HOSPITAL OR INSTITUTION OR STREET ADDRESS E. MAIN STREET		STREET ADDRESS (If rural give location) E. MAIN STREET	
3. NAME OF DECEASED (First) (Middle) (Last) WILLIAM DANIEL WALKER		4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 22, 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 23, 1861
9. AGE last birthday 96 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10b. KIND OF BUSINESS OR INDUSTRY	
Mine Foreman		Coal Miner	
11. BIRTHPLACE (State or foreign country) Union Co., Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONATHAN CLARK WALKER		14. MOTHER'S MAIDEN NAME ALICE PENLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-26-0520-A	
17. INFORMANT & ADDRESS J.W. WALKER, SHALLMAR, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Acute Pulmonary Edema			1 day
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease			2 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Bilateral Degenerated heart			10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1947 to Oct. 22, 1957 , that I last saw the deceased alive on Oct. 22, 1957 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
SIGNATURE Wolff Celandella		ADDRESS (Street, city, town, state) Kitzmillers, Md DATE SIGNED Oct. 22-57	
23. BURIAL, CREATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Oct. 25/57	NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	LOCATION (City, town, or county) (State) Elk Garden, W. Va.
24. REC'D BY REGISTRAR 10/24/57	REGISTRAR'S SIGNATURE W. Barrick	25. FUNERAL DIRECTOR'S SIGNATURE O. H. Shoreless ADDRESS Blaine, W. Va.	

RECEIVED

OCT 28 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 10691 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10691/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Garrett Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) F. Street		d. STREET ADDRESS F. Street	
3. NAME OF DECEASED (Type or print) Laura G. Welch		4. DATE OF DEATH October 18, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Md. Public school	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Weimer		14. MOTHER'S MAIDEN NAME Nancy Jane McRobie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Joseph H. Welch		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 744.0 DUE TO Myasthenia Gravis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 , to Oct. 18, 1957 , that I last saw the deceased alive on Oct. 18, 1957 , and that death occurred at 7:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 77 Oak St., Oakland, Md. Oct. 20, 1957	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/21/1957	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 10/21/57		24b. REGISTRAR'S SIGNATURE J. H. Welch	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1967

RECEIVED

10692

CERTIFICATE OF DEATH

1069266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETS NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELLAZAN ELIZABETH WINTERS				4. DATE OF DEATH Month Day Year OCT. 6 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE-13-1869	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oakland(rural), Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB HAUSER				14. MOTHER'S MAIDEN NAME MARGARET ROTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address CARL WINTERS OAKLAND MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypochromic Anemia						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1956 , to Oct 1957 , that I last saw the deceased alive on October 12, 57 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. I. Baumgartner M.D.				ADDRESS (Street, city or town, state) 2500 1st St Oakland Md		DATE SIGNED 10/7/57	
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-9-1957		22c. NAME OF CEMETERY OR CREMATORY RED HOUSE CEMETERY		22d. LOCATION (City, town, or county) (State) RED HOUSE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD				24a. REC'D BY REGISTRAR DATE 10/8/57		24b. REGISTRAR'S SIGNATURE John Brown	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITALS

1957

RECEIVED
OCT 9 1957
BUREAU V. S.

Unrecorded in Bureau

Unrecorded in Bureau